Present and Future Challenges Facing New Hampshire's Community Health Centers

Bi-State Primary Care Association
October 2000

3 South Street
Concord, NH 03301
603-228-2830
www.bistatepca.org

Acknowledgement

We wish to thank the New Hampshire Department of Health and Human Services, Office of Planning and Research, the Health Resources Services Administration's Bureau of Primary Health Care and the following Bi-State Primary Care Association members who participated in this project.

Ammonoosuc Community Health Services, Inc
*Littleton, Whitefield, Warren, Woods*ville

Avis Goodwin Community Health Center
Dover, Rochester

Coos County Family Health Services, Inc
Berlin

Families First Family Center
Franklin

Lamprey Health Care
Newmarket, Raymond

Manchester Community Health Center
Manchester

Neighborhood Health Center for Greater Nashua
Nashua

Present and Future Challenges Facing New Hampshire's Community Health Centers

National Overview

In response to the increasing number of people without adequate access to basic health care, particularly in the inner cities and rural areas of the country, the federal government provided initial funding for primary health services to disadvantaged communities in the mid 1960's. The Federal Office of Economic Opportunity's Neighborhood Health Center Program laid the foundation for community based health care.

In 1975, The Public Health Service Act, Section 330, was formally adopted to maintain federal grant funding for Community Health Centers (CHCs). The level of federal grant funding for CHCs has varied over time with changes in administrations and policy from an initial investment of $175 million with today's investment of $1,019 billion. Today, the Health Resources Services Administration (HRSA), Bureau of Primary Health Care (BPHC,) grants Section 330 funding to four New Hampshire CHCs as Federally Qualified Health Centers (FQHCs) and one Healthcare for the Homeless Center. The Bureau also recognizes two State-funded CHCs as Federally Qualified Health Center Look-a-Likes.

In 1989, federal legislation was enacted that required states to pay FQHCs reasonable cost of providing care to Medicaid patients. The intent was that federal grant dollars were to support services for uninsured and underinsured patients rather than subsidizing losses on Medicaid and Medicare.

More often than not, the underserved are living at or below the poverty level. Most health center patients have their care paid for by either Medicaid, Federal grants or through Medicare. Some are able to pay for services based on a sliding fee scale. In addition, health centers are struggling to serve the swelling ranks of uninsured and underinsured clients who continue to increase at a rate that far outpaces any growth in federal grant funding.

In 1999, health centers across the nation provided high quality, cost-effective, culturally appropriate, and accessible and affordable, preventive and primary health care services to more than 10 million[1] children and adults living in underserved urban and rural communities. Nationally, there are more than 700 health centers, which are represented at 3000 health care delivery sites. [2] Forty percent of the health center patients served are uninsured, 34% have Medicaid, 8% have Medicare and 18% have some health insurance. Comparatively, of the eight CHCs in NH, 41% are uninsured, 19% have Medicaid, 8% have Medicare, and 32% have some other health insurance.

[1] Bureau of Primary Health Care Policy Information Notice 2000-16. p.1

[2] Bureau of Primary Health Care Policy Information Notice 2000-16. p.1

Comparison of National and New Hampshire Community Health Center Users

National		NH
700	Total Number of organizations involved	8
10,000,000	Total Number of Users	42,259
40%	Total Percentage of Uninsured patients	41%
34%	Total Percentage of Medicaid patients	19%
8%	Total Percentage of Medicare patients	8%
18%	Total Percentage of Insured patients	32%

New Hampshire CHCs

For many years, there had been only one federally funded CHC in New Hampshire, Lamprey Health Care in Newmarket and Raymond. In the mid 1990's, two events impacted community-based health care in New Hampshire. In 1994, the State, with support from the Robert Wood Johnson Foundation and funds from the New Hampshire Health Care Transition Fund, established a Primary Care Practice Sights Initiative that provided an opportunity for categorical programs, such as child health centers and family planning programs, to transition into comprehensive primary care centers. This transition prepared the way for three new sites to receive federal Public Health Service Section 330 funds (hence, a total of four FQHCs).

Four other health centers are not federally funded, however, they receive primary care and/or categorical state funding. In 1996, two of these four State-funded primary care organizations achieved FQHC-Look-a-Like status. These two organizations met all BPHC Section 330 requirements including governance, comprehensive preventive and primary health care and services to all individuals regardless of their ability to pay, however, they do not receive Section 330 funding.

This report reflects the status of eight federal and state community health center organizations

providing comprehensive primary care to New Hampshire residents at thirteen sites in six of ten counties. All of these organizations are members of Bi-State Primary Care Association and have a solid track record in providing medical and social services to New Hampshire residents.

In the absence of a New Hampshire statewide public health system to deliver limited primary health care**,** these CHCs and their community partners fill the gap that is typically delivered by a state or county public health system.

Access to affordable primary and preventive medical and dental care is a challenge to New Hampshire's 96,000 uninsured. [3] Even those who are insured fear that a catastrophic health care event will destroy their financial stability. Caring for the uninsured has become more challenging as State financial support has remained at 1.2 million dollars since 1994, while the demand for services continued to increase by 51.2% during that time. The adequacy of New Hampshire's health care delivery system varies from community to community, county to county, rural to urban, and is dependent on the structure of the local health care market and environmental, as well as socioeconomic status of the community. Without New Hampshire's CHCs, many of the uninsured would fall into a gap of having no affordable access to health care.

The increased numbers of uninsured patients being seen by the CHCs is placing an undue financial burden of providing care without adequate reimbursement and an inability to subsidize uncompensated care. The CHC payer mix does not allow cost shifting to third party payers and thus, creates a dependence on grants and contracts.

New Hampshire's CHCs have experienced an increase in the demand for services by area residents. This is partially due to the lack of comprehensive services prior to 1994, as well as the growth in the uninsured and underinsured population and the effect of managed care. Managed care has placed performance criteria on private providers, who in the past could absorb a number of uninsured patients by cost shifting to other payers. Recent data indicates that physicians who derive a major portion of their revenue from managed care are less willing or able to provide charity care. [4] Those patients are now seeking care from the safety net providers who offer services regardless of the ability to pay. Today, 41% of CHC patients reflected in this report are uninsured.

Today's Challenges

- Long-term growth and sustainability of safety net providers due to the fluctuating insurance market which has placed unprecedented challenges and the potential to negatively impact populations most in need.

- Competition for market share as a result of the market challenge placed on mission-oriented organizations.

[3] NH Department of Health and Human Services, the New Hampshire Health Insurance Coverage and Access Survey. September 1999

[4] National Academy of Sciences, Institute of Medicine, America's Safety Net Intact but Endangered 2000 p. 2

- Mergers and acquisitions of insurance plans that have impacted the CHCs, as well as other safety net providers, in rate increases and unfavorable contract negotiations.

- Increased number of uninsured due to a rise in insurance premiums as employers were forced to evaluate their benefit packages and, in some cases, to drop health insurance all together.

- Retention of health center staff as staff are forced to choose participation in cost sharing of benefits, to become one of the uninsured or seek employment that offers fully funded benefit packages.

- Identification of culturally competent staff to provide services to New Hampshire's increasing minority population.

- Provision of strong enabling services such as social work, nutrition, transportation and translation, some of which are not directly reimbursed.

- Locating medical staff that is committed to serving the underserved population and patients that present a multitude of medical problems that stem from lack of long-term access to health care, poverty and education, is time consuming and demanding.

- Difficulty in determining the true number of underserved and underinsured in New Hampshire due to lack of data.

- Additional factors that impact CHC programs include the federal mandated FQHC medical and enabling services that must be provided, the relative high acuity level of patients seen at CHCs, complex social issues that burden patients and the need for staff to have strong cultural competent skill sets.

Finance

State financial support for CHCs is strained by State budget constraints. Through 1998, the State funded primary care through the Health Care Transition Fund and CHCs are now reimbursed through the State general funds. New Hampshire's current educational funding crisis, brought about through a Supreme Court decision, places all general funded programs at risk of significant reductions. Public funding is essential for the CHCs survival. Reductions in public funds have a potential impact on CHCs and the loss of money that should be dedicated for CHCs can be disastrous. One example is the tobacco settlement money, which was intended to serve as a repayment for tobacco-related illness incurred by those on federal health programs (i.e. Medicaid). New Hampshire, however, will not use these funds for health care but will use them to finance the State's educational funding shortfall.

Inadequate funding and increased need has placed a financial burden on CHCs. From a traditional business perspective many would view CHCs as bad risks. If they are measured in terms of their financial "profitability" they are bad risks. If they are measured in terms of their

essential community role as a major provider of primary care to the poor and the uninsured, their community cannot afford to loose them. Indeed, the CHCs have utilized and created unique partnerships within the community in order to leverage state and private funding to provide needed care.

Competing in the health care job market is another challenge to health centers. CHC staff salaries are on the low end of the competitive wage scale. Further, centers are not in the position to offer hiring bonuses or financial incentives. The reward is in service to the community. These are rare individuals, difficult to find and hard to recruit.

Finally, a growing number of health centers have outgrown their facilities. Struggling under perennially tight budgets, health centers have had few, if any, resources available for facility and infrastructure development. Access to capital is scarce; most grants restrict capital investments and the CHCs' face an uphill struggle to secure commercial loans.

The financial implications of the BBA '97 on New Hampshire's FQHCs and FQHC Look-a-Likes had the potential to reduce payments to 70% of cost by 2003. In 1998, according to analysis of the CHCs' cost reports, the average reimbursement per visit at a health center, for comprehensive medical care, including most enabling services, was $104.24. Under the BBA '97 formula, the amount would be reduced to $72.96 in 2003. The proposal would have reduced the health center payment rate each year as a percentage of costs. Health centers could not have provided comprehensive services at the proposed reimbursement rate and most would have closed prior to reaching the 2003 reimbursement level.

In 1999, recognizing the serious impact on the delivery of comprehensive primary care services to the Nation's most vulnerable populations, Congress enacted a three-year moratorium on the community health center provisions of 1997 Balanced Budget Agreement.

In response to BBA '97 and '99, the National Association of Community Health Centers (NACHC) and its members have initiated efforts to establish Safety Net Preservation legislation that would freeze the 1999 Medicaid reimbursement rate. Then, beginning in 2001, the rate would increase with inflation, as measured by the Medicare Economic Index for primary care. Thus, if the health centers become more efficient and lowered their costs, they would still receive the inflation-adjusted rate and, therefore, have the ability to reinvest in services to the uninsured.

New Hampshire's FQHCs and FQHC Look-a-Likes currently have an administrative agreement with the NH Department of Health and Human Services for cost based reimbursement or 133% of the Medicare rate (which ever is less) for Medicaid encounters. This agreement has been in effect for two years and appears that it will continue until a permanent solution can be reached. In addition, the State has agreed to a 90-day settlement on annual cost reports, while investigating alternative methods of interim reimbursement.

Managed Care Market

In 1997 and 1998, significant changes affected not only NH residents but also CHCs and other safety net providers. Cigna Heath Plan purchased Healthsource New Hampshire and Blue

Cross/Blue Shield of New Hampshire purchased Matthew Thornton Health Plan, a contractor for the voluntary Medicaid Managed Care program. In January 2000, Anthem Insurance Company of Indiana assumed control of New Hampshire BlueCross/BlueShield. In February 2000, Tufts Health Plan exited New Hampshire, Maine and Rhode Island. With the subsequent demise of Tufts, New Hampshire has been left with two major health plans: Anthem BC/BS of New Hampshire and Cigna Healthsource. Both organizations are for-profit companies headquartered out of state.

The commercial managed care market is dominated by two insurers, Anthem Blue Cross/Blue Shield of New Hampshire and Cigna Healthsource, controlling 80% of the insured market.

New Hampshire established a voluntary Medicaid Managed Care Program (MMC) in 1986. Until 1998, Healthsource, Tufts and Mathew Thornton Health Plan contracted with the state to enroll Medicaid eligible patients in to MMC. Currently, Matthew Thornton Health Plan (under Anthem Blue Cross/Blue Shield), is the only insurer offering a Medicaid managed care product with approximately 6,000 enrollees. CHCs do not participate in Medicaid Managed Care because the capitated rates paid by HMOs are less than the FQHCs encounter rate and cost settlement.

The State submitted an 1115 Waiver application in June 1994, and after several revisions submitted a final request in June 1997 (this request included a buy-in provision for low to moderate-income adults). The Waiver request was placed on hold when Congress approved the Chapter 21, Children's Health Insurance Program (CHIP) and New Hampshire opted to implement CHIP. The program was inaugurated in January 1999, and according to New Hampshire Healthy Kids Corporation, it has been successful in identifying and enrolling more than 9,000 children in Healthy Kids Silver and Healthy Kids Gold.

Services

FQHCs and FQHC Look-a-Likes are required by the Public Health Services Act, Section 330 to provide primary and preventive heath care services, regardless of ability to pay. The State funded CHCs have the same requirements as a result of their contracts with the State.

> Ambulatory services include comprehensive medical services, which are provided or arranged for both genders and all ages. The medical visits include the full scope of services that include Pediatrics, Obstetrics, Adult Medicine, Gynecology, Family Planning, Immunizations, and Family Medicine.
>
> Enabling services include translation, case management, nutrition, WIC, school-based services, transportation, risk assessment, health education, and outreach and enrollment.
>
> Extended services are provided for the management of chronic disease, for example: Asthma, Diabetes, Cardiovascular Disease, Tuberculosis, Thyroid, Tobacco addiction, HIV case management and counseling, etc.
>
> Referral Services are provided for all patients in need of specialty care and hospital care.

Profile of CHC Patients[5]

A high proportion of the patients of the eight community health centers in this report are low income, come from working families and delay care due to lack of financial resources and generally present multiple medical and social issues.

CHCs provide care to 42,259 New Hampshire residents with an average of 3.7 (158,221) visits per year.

Health center reports indicate that 33% of their patients are between 0-19, 60% are between 20–64 and 7% are 65 and over.

Currently 41% of the patients of the eight New Hampshire CHCs in this report are uninsured, which is 18% of New Hampshire's uninsured. The uninsured population rate by center ranges from 29% to 80%.

CHCs provide care to 19% of the New Hampshire's Medicaid population. The Mediaid population rate by center ranges from 12% to 35%.

Data

CHCs collect administrative, demographic, financial and utilization data, which are submitted to the State Office of Community and Public Health and Federal Bureau of Primary Health Care on an annual basis. The Unified Data System (UDS) information is used to ensure compliance with state and federal criteria and in developing strategic plans. Data from these reports allow CHCs to trend utilization patterns and performance, including growth and productivity and cost, which are important in the monitoring and evaluation of community health center programs in relation to local and national norms.

New Hampshire CHCs have partnered with the Dartmouth Family Practice Residency Program in implementing Medicalogic's electronic medical record software, Logician. Through this system, the centers are able to extract information electronically from patients records on demographics and diagnosis, practice management and create a practice profile.

Logician improves access to medical data such as immunization rates and credible information on health outcomes. Logician users are able to document disease specific outcomes, which impact the health status of CHC patients, as well as the State. A new pharmacy module will allow centers to fully integrate prescriptions and the Indigent Care Program information.

New Hampshire Logician users have established an evidenced based guidance group of providers and a users group of administrators and technical staff as a means to share information and discuss new tools to move forward.

[5] NH CHCs, 1999 Unified Data System Reports

The Dartmouth Family Practice Residency program and Capital Regional Healthcare support the project, which is a benefit to the centers in the participation in volume purchase of licenses and technical services.

Future Challenges

CHCs require stable, financial resources to continue to provide comprehensive primary care services and fulfill their mission. Dependence on a single, fixed stream of funding, subject to the potential volatility of shifts in policy and economic downturns is not an option.

We need to focus our efforts on meeting the State's need for caring for all the under- and uninsured. To meet the medical and dental challenges that face us and improve efficiency and cost effectiveness, CHCs must increase State and federal financial participation, establish new and lasting partnerships within communities, broaden services, and diversify resources.

This can only happen with a strong commitment from State government and from the organizations to continue to excel in the delivery of services. According to the March 2000 Institute of Medicine report entitled *America's Safety Net: Intact but Endangered:* "Until the nation addresses the underlying problems that make the health care safety net system necessary, it is essential that national, state, and local policymakers protect and perhaps enhance the ability of these institutions to carry out their mission…Failure to support these essential providers could have a devastating impact, not only on the populations who depend on them for care, but also on other providers that rely on the safety net to care for patients who they are unable or unwilling to serve".

CHCs are critical to serving the rising number of under- and uninsured in New Hampshire and need to be preserved, stabilized, grown and enhanced. With the increased demands in dental care and pharmaceutical costs, we need to assure that CHCs receive increased funding.

Medicaid reimbursement rates do not reflect the cost of providing care to the most vulnerable populations – the under- and uninsured. We need to assure that Medicaid rates are adequate and that there is sufficient reimbursement for enabling services and outreach and enrollment efforts that are not covered under cost based reimbursement.

As CHCs work with complimentary primary care providers in establishing partnerships to serve the uninsured in their communities, we need to assure that funding is directed to aid in the development of networking and partnership opportunities.

Because CHCs are essential in the community as a major provider of primary care to the poor and the uninsured, we need to assure that there is support and funding to increase the number of CHCs across the state. As CHCs grow and expand, so too would the assurances in meeting their capital needs. We need to support and fund all aspects of workforce recruitment and retention and assure resources to support clinical best practice models.